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THE POLITICS OF MEDICAID

LAURA KATZ OLSON (Columbia University Press, New York, New York, 2010), 416 pages, \$32.50.

*Reviewed by Nicole Huberfeld, J.D., Lexington, Kentucky.**

INTRODUCTION

Medicaid is the word on everyone's lips, not only because of the budgetary crisis many states are suffering, but also because the Supreme Court will decide two major cases regarding Medicaid this term, each of which has the potential to significantly alter the course of this long-standing safety net as well as the constitutional principles undergirding the program. Medicaid is a federal program that was intended to mainstream the very poor into the healthcare system by providing states with matching federal funds for particular expenditures on and provision of medical care. Without Medicaid, tens of millions of Americans would be uninsured and unable to access needed medical care, and hospital systems would collapse under the weight of charity care that is required by federal law. The program is often described negatively by politicians and in the media, despite the fact that polls consistently show that the public supports it, and despite the reality that Medicaid is the largest grant of federal money to the states, underlining the import of the program's entitlement to states, healthcare providers, and the poorest citizens.¹

Medicaid has a complex history and an opaque structure that is mysterious to the uninitiated. Someone who needs a pithy explanation for why the Medicaid program looks like it does will find that *The Politics of Medicaid* concisely tells the tale from a political scientist's point of view (240 pages of prose). Those who have studied Medicaid, however, are likely to find that the

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¹ Kaiser Commission on Medicaid and the Uninsured, *Key Questions About Medicaid And Its Role In State/Federal Budgets and Health Reform* 3 (Jan. 2011), at <http://www.kff.org/medicaid/upload/8139.pdf>.

first half of the book covers ground that has been traversed by other prominent sources, though the second half contains important insights. And, readers in either category, take note: Medicaid has changed significantly because of the Patient Protection and Affordable Care Act (ACA), which postdates publication, and which is the subject of major litigation as this review goes to press.

CHALLENGING THE STAKEHOLDERS

The introduction to *The Politics of Medicaid* promises that everyone is fair game. Olson appears to be particularly interested in indicting healthcare entities, and others that she calls “stakeholders,” for pushing the costs of Medicaid upward. [pp. 5-6] This idea sets the tone of the book, that politicians have ignored the true drivers of the program to the detriment of its enrollees, and that it is time to take a hard look at the entrenched interests that benefit wrongfully from America’s welfare medicine.

The initial chapters provide a cohesive picture of Medicaid’s history. But, much of the information has been covered in iconic books such as Robert and Rosemary Stevens’ *Welfare Medicine in America*, a study of the history and advent of the Medicaid Act written almost contemporaneously with its passage,² or more recent books such as Tim Jost’s *Disentitlement*, which contextualizes the role of Medicaid in the modern American healthcare delivery system.³ Further, the politics of Medicaid are profoundly complex, and yet strangely consistent, a problem that could have been addressed in greater depth here. Medicaid’s reliance on the idea of the deserving poor, and states’ role in serving them, can be traced to American colonies’ dependence on Elizabethan Poor Laws as a welfare model. The Poor Laws provided assistance to the same limited categories of deserving poor as Medicaid, and left localities to fend for themselves in assisting those deemed worthy of state assistance. For the first 46 years of its life, Medicaid was structured much in this way; the program served only the deserving poor (elderly, disabled, pregnant women, children), which, quantified, meant only about 40% of the impoverished citizenry. And, because the states and localities had always provided welfare medicine, the federal government paid homage to states’ rights in structuring Medicaid as well as all of its predecessor programs. The history relayed in this book only touches on the philosophical, path dependent nature of Medicaid’s institutional structure and the tensions it has fostered between the federal government and the states.

² ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* (1974).

³ TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH PROGRAMS AND A RIGHTS-BASED RESPONSE* (2003).

The first half of the book also describes the access problems that Medicaid enrollees have long faced, such as partial coverage of medical needs; selective coverage of healthcare; and general tinkering with the program depending on the state in which enrollees live, its fiscal strength, and its political sympathies. These problems are real, and they are regularly documented by such organizations as Kaiser Family Foundation and the Urban Institute. Likewise, the chapter regarding long term care (LTC) supplies a fine description of the problems inherent in the nursing home industry ("system" would be too generous), and Olson keenly notes that middle class families burden already limited Medicaid dollars greatly when it comes to LTC. But, cost shifting, problems with quality of care in LTC, and the idea that LTC is Medicaid's "800 pound gorilla" are also well-documented elsewhere. [pp. 130, 152]

Nonetheless, Olson also delivers insights in these early chapters. For example, she ties healthcare fraud to problems in quality of care, a link that often is ignored. Likewise, Olson is direct in describing how Medicaid's structure has been manipulated to allow for state exploitation of federal funds as well as for variations in states' programs that have led to lower quality of care for Medicaid enrollees. This is one of the open secrets of Medicaid, that the states manipulate their spending to increase their entitlement to federal funds. The federal government has been deferential to states regarding their operation of welfare medicine since the Social Security Act of 1935 started federal grants to the states for medical care, and that long path of obeisance to states' rights has resulted in states' ability to claim more federal dollars than may be their due. This is not the "entitlement problem" about which politicians generally pontificate, and so the illumination of states' rights in action that Olson provides and the plain accounting of this issue is valuable.⁴

The second half of the book tenders important observations. Chapter 7 describes the quality problems Medicaid has suffered as a program that is supposed to provide not only equal access but also equal care to the poor. It is nigh impossible for equal care to be provided with the low reimbursement rates that states pay, and Olson convincingly describes how, from the beginning, cost concerns have trumped quality of care in myriad ways. For example, Olson outlines how managed care has made Medicaid more expensive while providing often inferior care to enrollees, which exacerbates extant quality problems. At present, quality and access issues are of particular concern, as Medicaid providers and enrollees have been faced with states' efforts to balance budgets through Medicaid funding cuts, service cuts, and managed care expansions during the Great Recession.

⁴ The Urban Institute has also discussed this issue in some depth. *See, e.g.,* URBAN INSTITUTE, *FEDERALISM AND HEALTH POLICY* (John Holahan et al., eds., 2003).

A prominent case of state budgetary cuts limiting enrollee care has made it to the Supreme Court: California instituted 10% reimbursement cuts to address its budgetary crisis, and healthcare providers sought an injunction against the reductions based on the theory that the state was violating Medicaid's "Equal Access" provision, 42 U.S.C. section 1396a(a)(30)(A), and thus was violating the Supremacy Clause. The Court heard oral arguments in the case, consolidated into *Douglas v. Independent Living Center*, on the first day of the 2011 term, and it is being closely watched for a variety of reasons.⁵ The Solicitor General contended, in a controversial amicus brief and in oral arguments, that private parties should not be able to enforce the terms of the Medicaid Act against states because it is a spending statute and because the Centers for Medicare and Medicaid Services (CMS) is responsible for enforcing the law.⁶ The trouble with this theory, according to an amicus brief filed by former administrators of the Department of Health and Human Services (HHS), is that the agency has never had the resources to police states' "sufficient" payment to ensure equal access to the healthcare system for Medicaid enrollees.⁷ Further, the Solicitor General has pointed to draft regulations that are designed to clarify the Equal Access provision's sufficiency requirement, but the draft regulations facilitate no more than information gathering, and with no clear path to enforcement. The former HHS administrators argue that, while CMS has long received plenty of funding to ferret out fraud, it is understaffed and underfunded and has historically relied on private parties to highlight state failures in reimbursement. Thus, a very real, high-stakes example of the tensions highlighted in Chapter 7 is playing out before the Court.

This chapter also accuses federal prosecutors of being too focused on monetary recoveries rather than harm to enrollees through failures in quality or outright negligence (especially in nursing homes). Healthcare fraud prosecution has trumped quality of care prosecution, and prosecutors have focused on harm to the program rather than harms to enrollees; these choices have further pushed quality of care to the side. It would have been enriching for this point to have been explored more, as healthcare fraud has become its own big business with entrenched "stakeholders" who are focused on the headline-grabbing big settlement. For example, CMS recently published final regulations facilitating the Medicaid Recovery Audit System (Medicaid RACs), an initiative to recover billions of dollars in suspected waste and fraud

⁵ *Douglas v. Independent Living Center*, Docket Nos. 09-958, 09-1158, 10-283 (consolidated) (2011).

⁶ On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit, Brief for the United States as Amicus Curiae Supporting Petitioner, *Douglas v. Independent Living Center of Southern California, Inc.*, Nos. 09-958, 09-1158, 10-283 (consolidated) (2011).

⁷ Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *Douglas v. Independent Living Center of Southern California, Inc.*, Nos. 09-958, 09-1158, 10-283 (consolidated) (2011).

from the Medicaid program.⁸ Predictably, the press releases tied the import of the Medicaid RACs to the federal fisc rather than to quality of care or medical integrity. While Olson examines the False Claims Act as a possible solution to the quality problem, she provides just a few examples of successful quality-as-fraud prosecutions. Deeper exploration of the potential for a different kind of fraud prosecution would have been welcome. This chapter seems like it would be a fascinating book unto itself, the material is so rich and the issues so expansive.

Chapter 8 could be the most controversial. This chapter describes the “Medicaid medical industrial complex” by walking through each of the big healthcare players participating in the program and how they keep federal money flowing to serve their individual interests. The author, frustrated by the hand-wringing over the escalating costs of Medicaid, observes that few seem to be willing to take a hard look at the stakeholders and how they individually and collectively drive costs. Those who agree that the medical-industrial complex is overly powerful will probably find this chapter to be eye-opening and satisfying. Those who believe that healthcare providers suffer vilification while offering undervalued services are more likely to find this chapter frustrating. Likewise, the next chapter follows up by explaining how states leverage federal dollars for many state purposes that are often unrelated to Medicaid. Thus, Chapter 9 too could be read differently, depending on point of view: it either continues the theme of stakeholders being responsible for their own problems, or it is unsympathetic to states that shoulder the burden of welfare medicine in an era of escalating medical costs. Each of these chapters, too, could be a book unto itself.

As its conclusion states, the book paints a “picture of the social, economic, and political dynamics that have shaped the program over the decades, has attempted both to explain its inexorable growth and to explore the extent to which it meets the needs of low-income families.” [p. 223] Olson concludes that Medicaid impacts everyone, and yet it does not deliver on its promises; that cost containment is often dangerous; and that states are incapable of leading the way to better coverage. Readers sympathetic to these views will wish for further elucidation of the concerns articulated. In the end, however, the book calls for a move to national healthcare because medicine is a basic human right. This seems a logical conclusion to the arguments Olson puts forth, but it also feels a bit abrupt given the narrower focus of the rest of the monograph. The reader may feel, once again, that this observation deserves additional attention.

Unfortunately, the book suffers from a careless edit, both in form and substance, that can detract from its authority. For example, the book asserts that

⁸ 76 FED. REG. 57808 (Sept. 16, 2011).

the Supreme Court “upheld” the constitutionality of the Medicaid Clawback, a provision of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) that conditioned state participation in Medicaid on paying the federal government for certain drug costs that the MMA had shifted to Medicare. This is not accurate.⁹ The Supreme Court denied the states’ motion for leave to file a complaint seeking an injunction against the implementation of the Clawback. Then the states lost steam in lower federal courts seemingly in the hope that political maneuvering would help to end the Clawback. Perhaps denial of the petition for original jurisdiction was mistaken for upholding the constitutionality of the provision.

Nevertheless, too many Medicaid policy judgments have been made in an information vacuum, so having a book that efficiently summarizes the Medicaid program and highlights its real troubles could help to alleviate this problem. But, this leads to a final caveat: the ACA amends and expands Medicaid in important ways, which impacts a number of the points made in the book. As I have illustrated in *Federalizing Medicaid*, ACA effectuated a major philosophical shift by rendering everyone up to 133% of the federal poverty level eligible to apply for Medicaid.¹⁰ For the last 46 years, as was noted above, only the deserving poor have been eligible to enroll. Now, not only will Medicaid be open to all citizens who meet the requisite poverty levels as of 2014, but also the federal government will almost totally fund this new population.¹¹ Thus, some of Olson’s criticisms are moot, especially the ongoing critique of Medicaid serving only the deserving poor. Of course, given the Supreme Court’s grant of the petition for certiorari regarding the constitutionality of the Medicaid expansion, the particulars of ACA may themselves change or be entirely eliminated. These sorts of sea change are a natural hazard when writing about a program that has been amended nearly every year since its inception.

CONCLUSION

The Politics of Medicaid provides a service in succinctly describing the state of the program before healthcare reform, its shortfalls, and some solutions. The book reveals labyrinthine complexity facilitated by wrong-headed focus and constant bickering against the backdrop of real need, which is seemingly forgotten. Professor Olson reminds us, at a key moment, that Medicaid is more than just headline grabbing politics—it is a lifeline for our most impoverished citizens, and one that deserves more careful attention.

⁹ Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C.L. REV. 441 (2008).

¹⁰ Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CON. L. 431 (2012).

¹¹ Patient Protection and Affordable Care Act, Pub. L. 111-148, § 2001 (enacted Mar. 23, 2010).